STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000000	This visit was for a State Residential Licensure Survey. Survey Dates: January 7, 8, and 9, 2015 Facility Number: 010064 Provider Number: 010064 AIM Number: N/A Survey Team: Karina Gates, Generalist, TC Beth Walsh, RN Angie Stallsworth, RN Tom Stauss, RN Census Bed Type: Residential: 51 Total: 51 Census Payor Type: Other: 51 Total: 51 Sample: 10 These state findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 15, 2015 by Cheryl Fielden, RN.	R000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to ensure tools, knitting needles, and a chemical were kept secured on the locked Memory Care Unit, and to ensure the First Floor Servery (serving kitchen) doors were closed and locked. This had the potential to affect 2 cognitively impaired, independently ambulatory residents on the Memory Care Unit (Residents #39 and #49) and 1 of 33 residents residing on the First and Second Floors (Resident #4).	R000148	**1.Corrective Action for affected/cited resident** **There was no negative outcome with residents identified during survey process. Items listed in this citation were removed immediately and/or areas secured to prevent access.** **1.How to Identify Other Residents/Associates with potential for similar events:** **An environmental inspection of the community was completed by the ED on 1/8/2015 and no further potential hazards were found.**	02/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. An environmental tour was conducted with the Maintenance Director on 1/8/15, at 11:00 a.m. A common area of the locked Memory Care Unit was observed with a tool box on top of a 9 bin cubical unit. A pair of pliers was observed inside of the tool box. One of the bins was labeled, "Handyman Cube." Inside was a hammer, 9 wrenches, 3 pliers, 2 screwdrivers, 8 one and a half inch screws, and an oil filter wrench. Adjacent to the 9 bin cubicle unit, was a second 9 bin cubicle unit. One bin was labeled, "Knitting Cube." Inside were 2 long, knitting needles with pointed ends. No staff members were observed in the area. An interview was conducted with LPN #4 on 1/8/15, at 11:40 a.m., regarding the objects found inside of the cubes. She stated, "That's probably a bad idea. General rule is anything you should keep away from children, you should keep away from Alzheimer's residents." LPN #4 pulled the tools and knitting needles from the cubes and stated, "I will have (name of Program Manager) go behind me and recheck these cubes." An interview was conducted with the Program Manager and Health and		**1.Systemic Changes you will make:** **An all staff inservice will be completed by 2/1/2015 to educate associates on being proactive in the preparation of the environment for residents that will include the topic of: Securing kitchenette doors where access to steam tables are, proper use and storage of items such as tools and knitting needles and chemicals that could be harmful or listed as "Keep out of reach of children."** **1.Monitoring Q.A. plan:** **A Safe Environment Audit Tool for the community has been developed and the ED or Designee will tour and inspect the community weekly to ensure no hazard exist and correct any potential hazards found.** **Audit outcomes will be reviewed at upcoming Quality Assurance Meetings. The Executive *Director* will be responsible for directing additional action, based on audit findings.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Wellness Director on 1/8/15, at 1:25 p.m. The Program Manager indicated, "Those are life enrichment boxes, used as activities." The Health and Wellness Director indicated, "I would feel better if they were in a secured place." An observation of a large bowl, sitting on top of a 9 bin cubicle unit was made on 1/9/14 at 9:47 a.m., on the locked Memory Care Unit. The bowl contained 2 wash cloths, covered in a blue, watery liquid, 2 inches high. The bowl smelled of lemons. Residents #39 and #49 were observed in the area. No staff were present. An interview was conducted with Housekeeper #5 on 1/9/14, at 9:50 a.m. She indicated the bowl did not belong to housekeeping, and she did not know for what the bowl was used. She stated, "My stuff's locked up." Housekeeper #5 took the bowl to CNA #6 in the kitchen area. CNA #6 indicated the bowl was used to wash residents' hands prior to meals, and the lemon scent was oil. CNA #6 provided the bottle of oil used for the lemon scent. The side of the bottle indicated, "Not to be taken internally. Keep out of reach of children and pets." An interview was conducted with the Administrator on 1/9/14, at 10:20 a.m.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	She indicated everyone on the Memory Care Unit was cognitively impaired, Residents #39 and #49 were independently ambulatory, and there had been 6 resident to resident, physical altercations on the Memory Care Unit in the last year. 2. During initial tour with the Health and Wellness Director (HWD), on 1/7/15 at 11:15 a.m., the HWD indicated Resident #4 was listed in rooms on the First and Third Floors (Memory Care-Dementia Unit) on the Resident Suite and Telephone List, dated 1/7/15, because he currently resided on the First Floor but there were plans to move him to the Memory Care Unit (Third Floor) due to changes in his cognition. During a random observation, on 1/8/15 at 1:30 p.m., the First Floor Servery doors were observed opened and the Steam Table was observed on. No staff were located in the vicinity of the Servery. On 1/8/15, at 1:41 p.m., during an observation with the Administrator and the HWD, the Administrator indicated the Steam Table was hot to touch and steam rose from the Steam Table when the Administrator lifted the lid off of one of the sections with water. The Administrator indicated the Servery			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	doors should be shut after meal service. During an interview with the HWD, on 1/8/15 at 1:45 p.m., the HWD indicated Resident #4 was currently residing on the First Floor but the Facility would like to move him to the Memory Care (dementia) unit for impaired cognition. The HWD further indicated Resident #4 was able to independently move his wheelchair. The HWD also indicated there was a potential safety concern for Resident #4 with the Steam Table being accessible. On 1/8/15 at 2:00 p.m., the HWD indicated there was no documentation related to moving Resident #4 due to impaired cognition, but the Facility thought the move would beneficial and the Resident's family agreed to the move. At 2:47 p.m., on 1/8/15, the Administrator indicated Maintenance was changing the locks on the First Floor Servery to a keypad type lock, so that only staff members can access the Servery.			
R000217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure residents' service plans were signed by the resident or legal representative for 4 of 10 residents reviewed for service plans. (Residents #2, #11, #13, and #50) Findings include: 1. The clinical record for Resident #11 was reviewed on 1/7/15, at 2:00 p.m. The 12/1/14 Personal Service Assessment and 12/19/14 Personal	R000217	**1.Corrective Action for affected/cited resident** **There was no negative outcome with residents identified concerning this area. Resident's service plans have been signed by the resident or legal representive.** **1.How to Identify Other Residents/Associates with potential for similar events:** **A complete audit of medical records will be performed by 2/1/2015 to ensure all resident service plans have been reviewed and the resident or legal**	02/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Service Plan for Resident #11 were not signed by Resident #11. An interview was conducted with Resident #11 on 1/7/15, at 1:40 p.m. He indicated he was not sure if he participated in the development of his service plan. An interview was conducted with the Health and Wellness Director on 1/7/15, at 2:07 p.m. She indicated Resident #11's service plan was not signed by the resident, but it should be.2. Resident #2's record was reviewed on 1/7/15 at 12:19 p.m. The record indicated Resident #2 was admitted to the facility on 12/31/14. A "Personal Service Assessment", dated 12/29/14, was not signed by Resident #2 or a legally authorized representative for the resident. On 1/7/15 at 2:03 p.m., during an interview with the Health & Wellness Director, she indicated resident service plans, including pre-assessments used as temporary service plans, should be signed by the resident or an authorized representative for the resident. She also indicated Resident #2 did not have a signature on the temporary service plan or an actual service plan as of the resident's admission to the facility on		**representative has been given opportunity to review, ask questions and sign service plans.** **1.Systemic Changes you will make:** **All service plans will be reviewed and signed by residents or legal representatives. In the case where legal representative is not available, the HWD will mail the plan with a self- addressed stamped envelope accompanied with a letter to the legal representative to give opportunity to visit or call for a conference or to sign the plan and return. In the case where the legal representative does not respond a copy of the HWD correspondence will be filed in the chart as proof of notification and attempt to conference with the legal representative.** **1.Monitoring Q.A. plan** **The HWD will perform an audit of all medical records monthly to ensure all service plans; initial, or reassessments have been reviewed, signed or sent to legal representatives via mail for review and follow up.** **Audit outcomes will be reviewed at upcoming Quality Assurance Meetings. The Executive *Director* will be responsible for directing additional action, based on**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12/31/14. She indicated the facility was using a "Personal Service Assessment", dated 12/29/14, as Resident #2's service plan until the actual service plan could be completed by staff. 3. Resident #50's record was reviewed on 1/7/15 at 1:44 p.m. The record indicated Resident #50 admitted to the facility on 3/22/14. A "Personal Service Assessment" for Resident #50, dated 3/13/14, was not signed by Resident #50 or a legally authorized representative for the resident. A "Personal Service Plan" for Resident #50, dated 8/8/14, did not have a signature of Resident #50 or a legally authorized representative. On 1/8/15 at 9:05 a.m., during an interview, the Health and Wellness Director indicated the facility could not provide a personal service plan for Resident #50 which was signed by either the resident or a legally authorized representative. 4. The clinical record for Resident #13 was reviewed on 1/7/15 at 11:15 a.m. The current diagnosis included, but were not limited to, hypertension, osteoporosis, and coronary artery disease. Resident #13's was admitted to the facility on 1/3/15.		**audit findings.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A "Personal Service Assessment" was dated on 12/6/14 for Resident #13. This assessment did not indicate the resident or power of attorney's signature. An interview with the Health Wellness Director (HWD) was conducted on 1/7/15 at 2:03 p.m. The HWD indicated the evaluation prior to the admission (Personal Service Assessment) was acting as the service plan upon admission. The HWD further indicated a resident or power of attorney's signature was needed for an initial and annual service plan. A Personal Service Plan was provided by the Health Wellness Director on 1/8/15 at 12:30 p.m. This plan indicated Resident #13 signed on 1/8/15. The policy, "Personal Service Plan," dated 1/1/09, provided by the Health Wellness Director on 1/8/15 at 1:00 p.m. indicated, "...Policy Detail....5. Upon initial review and subsequent changes, members of the community care team and the resident/legally responsible party will sign the Personal Service Plan...."			
R000349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure a resident's physician 's orders were accurate, regarding diabetic care, for 1 of 10 residents reviewed for clinical records. (Resident #20) Findings include: The clinical record for Resident #20 was reviewed on 1/7/15, at 2:00 p.m. The diagnoses for Resident #20 included, but were not limited to, type II diabetes. The January, 2015 Physician's Orders for Resident #20 indicated the following 3 orders: "Call (name of physician) if blood sugar > 250," effective 6/6/14; "(Name of blood sugar monitoring machine) 3 times a day - for blood sugar < 60 or > 150 call M.D.," effective 6/4/14; "Regular insulin per sliding scale: 201-250 = 3 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units," effective 6/10/14. An interview was conducted with LPN #3 on 1/8/15, at 10:47 a.m. She indicated	R000349	**1. Corrective Action for affected/cited resident** **There was no negative outcome with the resident identified during the survey process. The orders related to diabetic care for this resident were immediately clarified by the doctor via the HWD.** **1.How to Identify Other Residents/Associates with potential for similar events:** **A complete audit of medical records of all diabetic residents in the community will be performed by 2/1/2015 to ensure orders are clear and concise by the HWD. All diabetic residents have appropriate, clear and concise orders.** **1.Systemic Changes you will make:** **The HWD will audit all Diabetic residents' orders monthly to ensure orders are clear and concise. The HWD will review all new orders daily when on duty to verify orders are appropriate, clear and concise.**	02/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the above mentioned 6/4/14 and 6/6/14 orders were old, and stated, "What we do now is the sliding scale, and we call if over 400." An interview was conducted with the Health and Wellness Director on 1/8/15, at 10:55 a.m. She indicated, "I will get a clarification for calling the doctor. I would think the over 250 order overrides the over 150 order, since (a blood sugar reading) within 150 is normal." An interview was conducted with the Health and Wellness Director on 1/8/15, at 1:00 p.m. She indicated, "I called the doctor's office. They thought the sliding scale. They are going to d/c (discontinue) the other 2 (orders)....Everyone should have questioned these orders." On 1/9/15, at 9:25 a.m., the Health and Wellness Director provided a Fax Physician Order Sheet for Resident #20, clarifying the discontinuation of the 6/4/14 and 6/6/14 physician notification orders and a new physician notification order to call if blood sugar is over 400.		**1.Monitoring Q.A. plan** **The HWD will perform an audit of all medical records of Diabetic residents to ensure orders are clear and concise and will clarify orders with doctor if not.** **Audit outcomes will be reviewed at upcoming Quality Assurance Meetings. The Executive *Director* will be responsible for directing additional action, based on audit findings.**	
R000409	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on interview and record review, the facility failed to provide a statement in which a resident was free of pulmonary tuberculosis (TB) for 1 of 7 residents reviewed for an annual assessment. (Resident #13) Findings include: The clinical record for Resident #13 was reviewed on 1/7/15 at 11:15 a.m. The current diagnoses included, but were not limited to, hypertension, osteoporosis, and coronary artery disease. Resident #13 was admitted to the facility on 1/3/15. A chest x-ray report dated 12/22/14 was reviewed by (name of Radiologist) on 1/7/15 at 11:30 a.m. This report was conducted for a "screening exam for pulmonary tuberculosis." It did not indicate a statement Resident #13 was free of communicable disease. A Vaccination and Tuberculosis (TB) Screening Record indicated a TB screening was initiated on 1/5/15. An interview with the Health and Wellness Director conducted on 1/7/15 at 1:20 p.m. indicated she was unaware	R000409	**1. Corrective Action for affected/cited resident** **There was no negative outcome with the resident identified during the survey process. The resident identified has since been medically cleared (by physician) of being free of communicable disease (in reference to TB).** **1.How to Identify Other Residents/Associates with potential for similar events:** **A complete audit of medical records of all residents in the community will be completed by 2/1/2015 to ensure all resident have CXR that address that they are free of communicable disease by the HWD. All residents have CXR or Physician statements that state they are clear of communicable disease (related to TB).** **1.Systemic Changes you will make:** **The HWD/ED will not allow residents to be admitted without a CXR that addresses that the resident is free of communicable disease (related to TB).** **1.Monitoring Q.A. plan** **An audit of all new residents' information will be performed by the HWD/ED prior to admission.**	02/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT FALL CREEK LLC	5011 KESSLER BLVD E INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	there was no documentation stating Resident #13 did not have pulmonary tuberculosis.		**These audits will be reviewed monthly by the ED.** **Audit outcomes will be reviewed at upcoming Quality Assurance Meetings. The Executive *Director* will be responsible for directing additional action, based on audit findings.**	